

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

0 2 — 0 1 4

2. STATE:

CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

July 1, 2002

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

a. FFY _____ \$No significant

b. FFY _____ \$impact _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

N/A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):Supplement 12a to attachment 2.6-A
page 6

N/A

Supplement 12b to attachment 2.6A,
page 21

10. SUBJECT OF AMENDMENT:

Section 1933(b) Program Desregards

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED: The Governor's office
does not wish to review State Plan
amendments

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Gail L. Margolis

14. TITLE:

Deputy Director, Medical Care Services

15. DATE SUBMITTED:

6/26/02

16. RETURN TO:

Department of Health Services
Attn: State Plan Coordinator
714 P Street, Room 1640
Sacramento, CA 95814**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

June 26, 2002

18. DATE APPROVED:

September 20, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

July 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Linda Minamoto

22. TITLE:

Associate Regional Administrator
Division of Medicaid

23. REMARKS: